PROVIDENCE Health Plan

Healthcare Services Medical & Pharmacy Policy Alerts

This is the June 1, 2020 issue of the Providence Health Plans, Providence Health Assurance and Providence Plan Partners, Medical and Pharmacy Policy Alert to our providers. The focus of this update is to communicate to providers' new or revised Medical or Pharmacy policy changes. The Health Plan has a standard process to review all Medical & Pharmacy Policies annually. Policies will be available for review on ProvLink and via the PHP website at: https://healthplans.providence.org/providers/provider-support/medical-policy-pharmacy-policy-and-provider-information/

The Provider Alert, Prior Authorization Requirements, and Medical policies are all available on ProvLink and through the link above.

Number 248

June 1, 2020

Effective July 1, 2020:

Colorectal Cancer Screening

In response to the 2019 US Multi-Society Task Force recommendations (LINK), medical policy criteria will now be applied to colonoscopy screening intervals for average risk patients. The USMSTF recommendations extend the surveillance interval for patients with 1-2 tubular adenomas less than 10 mm from 5-10 years to 7-10 years. In addition, the Task Force made a weak recommendation to extend the surveillance interval for patients with 3-4 tubular adenomas from 3 years to 3-5 years. If a provider would like a copy of the policy or has any additional questions, please email: PHPMedicalPolicyInquiry@providence.org

Surgical Site of Service for Total Knee Arthroplasties

Beginning 7/1/2020, prior authorization requests for total knee arthroplasties will only be required for inpatient locations (POS 21). Requests for outpatient or ASC locations (POS 22 and 24, respectively) will no longer require prior authorization.

PROVIDENCE Health Plan

Here's what's new from the following policy committees:

MEDICAL POLICY COMMITTEE

Effective August 1, 2020

Genetic Testing: Diagnostic Evaluation of Interstitial Lung Disease (All Lines of Business Except Medicare) GT445	**NEW Policy** A new policy has been created to address the use of genomic sequencing classifiers for the diagnostic evaluation of interstitial lung disease (i.e., Envisia® Genomic Classifier by Veracyte, Inc.) as investigational and not covered. **Codes/PA:** No specific codes, unlisted molecular path procedure code (81479) added to policy
Genetic Testing: Diagnostic Evaluation of Interstitial Lung Disease (Medicare Only) GT444	**NEW Policy** Creation of Medicare only policy as Medicare allows coverage of the Envisia Genomic Classifier under LCD L37891. **Codes/PA:** No specific codes, unlisted molecular path procedure code (81479) added to policy **CMS Guidance:** • Local Coverage Determination (LCD): MolDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test (L37891) • Local Coverage Article (LCA): Billing and Coding: MolDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test (A57420)

Effective July 1, 2020

Breast Surgery: Reduction Mammoplasty (All Lines of Business Except Medicare) **SUR164**	**Annual Update** Criteria for those who are under the age of 18 and requesting reduction mammoplasty have been added. In addition to the general criteria, those who are under the age of 18 years also must have documented stability of breast size for at least one year and completion of puberty changes. 60-day notice will be provided for these additional criteria for those who are under 18 years of age. **Codes/PA:** No change to coding or PA

Breast Surgery: Reduction Mammoplasty (Medicare Only) **SUR427**	**Annual Update** Update to the new Medicare policy format. No changes to policy coverage, continue to use Local Coverage Determination (LCD): L37020, Plastic Surgery. Added the reference coding article Local Coverage Article (LCA): A57222, Billing and Coding: Plastic Surgery. **Codes/PA:** No change to PA or coding **CMS:** • Continue to use LCD: L37020, Plastic Surgery • Added LCA: A57222, Billing and Coding: Plastic Surgery
Surgical Site of Service **UM387**	**Interim Update** No change to criteria (see Informational section for most recently approved policy). This interim update recommendation is simply to add the facility location coding configuration. **Codes/PA:** Request to configure pre-authorization to only apply to requests for the following codes made with location code 21 (inpatient hospital). • 27445 Arthroplasty, knee, hinge prosthesis (eg, Walldius type) • 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) • 27486 Revision of total knee arthroplasty, with or without allograft; 1 component • 27487 Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component
Rhinoplasty (Medicare Only) **SUR444**	**Interim Update** No change in coverage criteria. Adding PA to all codes per new CMS directive and guidance from RCGA. **Codes/PA:** All codes now require PA per new directive from CMS. 86 claims in 2019 .See below info. for additional background info. **CMS:** • Local Coverage Determination (LCD): Plastic Surgery (L37020)

Effective June 1, 2020

Back: Artificial Intervertebral Discs (All Lines of Business Except Medicare) **SUR138** *Previously: Back: Artificial Intervertebral Discs*	**Annual Update** No changes to criteria, although criteria I. G. and IV.G. now refer reader to relevant Tables instead of listing contraindications outright. Cervical artificial disc replacement (ADR) at a single or at two contiguous levels, and lumbar artificial disc replacement at a single level remain medically necessary and covered. Cervical and lumbar hybrid procedures remain investigational. **Codes/PA:** No coding changes; 10 codes continue to require PA

Back: Artificial Intervertebral Discs (Medicare Only) **SUR449**	**New Policy** No change to criteria. Policy broken out from above policy, updated to new "Medicare Only" format. Cervical artificial disc replacement and hybrid procedures follow commercial criteria. **Codes/PA:** No coding changes; 10 codes continue to require PA **CMS:** • National Coverage Determination (NCD) for Lumbar Artificial Disc Replacement (LADR) (150.10) • Local Coverage Determination (LCD): Non-Covered Services (L35008) • Local Coverage Article: Billing and Coding: Non-Covered Services (A57642)
Breast Implant Removal (All Lines of Business Except Medicare) **SUR163** *Previously: Breast Implant Removal*	**Annual Update** Surgical removal and/or replacement of any type of breast implant after mastectomy or lumpectomy remains medically necessary. Surgical removal of a cosmetically placed breast implant remains medically necessary and covered for select indications (e.g. implant failure, infection). Recommending liberalizing list of covered indications to include the following: • Extrusion/exposure of implant through skin, (7 of 8 payers) • Added criterion allowing for removal of Allergan Biocell, per LS recommendation • Contralateral implant may be removed following mastectomy, lumpectomy in affected breast, or when affected breast meets criterion III. (6 of 8 payers; LS and BG approved) **Codes/PA:** No coding changes; 7 codes continue to require PA.
Breast Implant Removal (Medicare Only) **SUR448**	**New Policy** No change to criteria. Policy broken out from above policy, updated to new "Medicare Only" format. **Codes/PA:** 7 codes already PA'ing. **CMS:** • Local Coverage Determination (LCD): Plastic Surgery (L37020) • Local Coverage Article: Billing and Coding: Plastic Surgery (A57222)
Genetic Testing: Reproductive Planning and Prenatal Testing (All Lines of Business Except Medicare) **GT236**	**Interim Update** **Background:** Genetic testing for spinal muscular atrophy (SMA) may be performed for diagnostic, prognostic, and carrier screening purposes. The appropriate CPT to bill for the *SMN1* gene which we have long considered to be considered medically necessary when criteria are met, also includes *SMN2* gene testing when performed. Labs around the country commonly reflex to *SMN2* testing by default without provider consultation, and denying *SMN1* testing on the basis of *SMN2* being included in the claim has become a repeat concern in Medical Policy. • Liberalize our criteria on carrier screening for spinal muscular atrophy to include *SMN2* gene testing in addition to *SMN1*. • Expand on the criteria note that states the policy does not pertain to invasive prenatal diagnostic testing, which is considered medically necessary. The note now specifies that invasive prenatal diagnostic testing includes but is not limited to *SMN1* and *SMN2* gene testing. **Codes/PA:** No change to pre-authorization or coding. Will leave PA on for carrier screening.
Allergy Testing (All Lines of Business Except Medicare)	**Annual Update** No change to criteria. In vivo and in vitro allergy testing remain medically necessary and covered when criteria are met. Multiallergen IgE screening remains not medically necessary. Re-reviewed frequency limits for medically necessary tests: still in line with other payers; no recommended changes.

LAB105	**Codes/PA:** No coding changes; no codes require PA.
Allergy Testing (Medicare Only) **LAB394**	**Annual Update** No change in Medicare guidance. In vivo and in vitro allergy testing remain medically necessary and covered when criteria are met. Policy now in new "Medicare Only" format. **Codes/PA:** No coding changes; no codes require PA **CMS:** • Local Coverage Determination (LCD): Allergy Testing (L36402) • Local Coverage Article: Billing and Coding: Allergy Testing (A57473)
Back: Discography **SUR121**	**Annual Update** No change in coverage criteria. Discography is considered investigational and is not covered for all indications, including, but not limited to use as a diagnostic procedure for determining the need for spinal fusion. **Codes/PA:** No coding or PA changes
Back: Intradiscal Procedures for Low Back Pain (All Lines of Business Except Medicare) **SUR127**	**Annual Update** No change in coverage criteria. Thermal intradiscal and non-thermal intradiscal procedures are considered investigational and are not covered for the treatment of low back pain. **Codes/PA:** Removing codes 62287 and S2348 as they were deemed not appropriate for this policy. However, these codes will continue to be investigational under the "Back: Fusion and Decompression Procedures" policy. There are no PA changes.
Back: Intradiscal Procedures for Low Back Pain (Medicare Only) **SUR434**	**Annual Update** No change in Medicare criteria. Thermal intradiscal procedures are considered not medical necessary and are not covered for the treatment of low back pain. **Codes/PA:** Removing codes 62287 and S2348 as they were deemed not appropriate for this policy. However, these codes will continue to be investigational under the "Back: Fusion and Decompression Procedures" policy. There are no PA changes.
Bronchial Thermoplasty **SUR113**	**Annual Update** No change in coverage criteria. Bronchial thermoplasty is considered not medically necessary and is not covered as a treatment of any condition, including, but not limited to, asthma. **Codes/PA:** No coding or PA changes
Cardiac: External Ambulatory Electrocardiography (All Lines of Business Except Medicare) **MED176**	**Annual Update** No criteria changes. External Cardiac Loop Recorders (ELR) and External Cardiac Patch Recorder; and mobile cardiac outpatient telemetry (MCOT) remain medically necessary and covered when criteria are met. MCOT remains investigational for diagnosing atrial fibrillation after cryptogenic stroke. **Codes/PA:** No coding changes; 4 codes continue to require.

Cardiac: External Ambulatory Electrocardiography (Medicare Only) **MED433**	**Annual Update** No criteria changes. CMS continues to cover electrocardiographic monitoring services when criteria are met. **Codes/PA:** No coding changes; 4 codes continue to require. **CMS:** • National Coverage Determination (NCD) for Electrocardiographic Services (20.15) • Local Coverage Determination (LCD): Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring) (L34636)
Cardiac: Left Atrial Appendage Devices (All Lines of Business Except Medicare) **SUR170**	**Annual Update** No change to criteria. **Codes/PA:** No change to coding or PA
Cardiac Left Atrial Appendage Devices (Medicare Only) **SUR171**	**Annual Update** Update to new Medicare format. No changes to criteria. Continue to use National Coverage Determination (NCD) for Percutaneous Left Atrial Appendage Closure (LAAC) (20.34). Moved other billing assistance references into CMS guidance. **Codes/PA:** No change to coding/PA **CMS:** • Continue to use National Coverage Determination (NCD) for Percutaneous Left Atrial Appendage Closure (LAAC) (20.34) • CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 3515, SUBJECT: Percutaneous Left Atrial Appendage Closure (LAAC) • Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, Section 69
Cardiac: Transcatheter Aortic Valve Replacement (TAVR) (All Lines of Business Except Medicare) **SUR179**	**Annual Update** No change to criteria **Codes/PA:** No change to coding/PA
Cardiac: Transcatheter Aortic Valve Replacement (Medicare Only)	**Annual Update** Updated to the new Medicare policy format. A new version of National Coverage Determination for Transcatheter Aortic Valve Replacement (TAVR) (20.32), effective 06/21/2019 has replaced the previous version. The linked document has all updated language in red. According to the NCD, "The purpose of this change request (CR) is to inform MACs that effective June 21, 2019, CMS will continue to cover TAVR under Coverage with Evidence Development (CED) when the procedure is furnished for the treatment of symptomatic aortic stenosis and according to an FDA approved indication for use with an approved device, in addition to the coverage criteria outlined in the NCD Manual." The previous version can

SUR429	be viewed here for comparison. Language updates are more explanatory, more liberal, and in some cases more restrictive than the previous version. The majority of the updates are clarifying however, and thus no 60-days notice will be given. **Codes/PA:** No change to coding or PA **CMS:** • National Coverage Determination for Transcatheter Aortic Valve Replacement (TAVR) (20.32) version 2, effective 06/21/2019 • Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, Section 290 *(scroll to Section 290 in Table of Contents and click on* **290 – Transcatheter Aortic Valve Replacement (TAVR) Furnished on or After May 1, 2012.***)*
Cefaly Device for Treatment of Migraine Headaches **DME181**	**Annual Update** No change to criteria: Cefaly Supraorbital Transcutaneous Neurostimulator device is considered investigational and not covered as a treatment of any condition, including migraine headache. **Codes/PA:** 2 unlisted codes
Cochlear Implants and Auditory Brainstem Implants (All Lines of Business Except Medicare) **SUR240** *Previously Titled:* *Hearing: Cochlear Implants and Auditory Brainstem Implants (All Lines of Business Except Medicare)*	**Annual Update** • Decreasing the age allowed for cochlear implants from 12 months to 9 months, based on the updated FDA approval for Cochlear®. Criteria language updated to "medically necessary in children *up to* 17 years of age". • All other cochlear implant criteria remain unchanged. • Auditory brainstem implants remain medically necessary and covered. **Codes/PA:** No coding or PA changes
Cochlear Implants and Auditory Brainstem Implants (Medicare Only) **SUR391** *Previously Titled:*	**Annual Update** Criteria moved into new Medicare format. No changes to relevant Medicare coverage documents. **Codes/PA:** No coding or PA changes **NCD/LCDs:** NCD for Cochlear Implantations 50.3

Hearing: Cochlear Implants and Auditory Brainstem Implants (Medicare Only)	
Definition: Confined to the Home **MED197**	**Annual Update** No criteria/definition changes or changes to "confined to home" (homebound) definitions. Patients are eligible to received home health services when criteria are met. **CMS:** • Medicare Benefit Policy Manual: Chapter 7 – Home Health Services • Medicare Learning Network® (MLN). Home Health – Clarification to Benefit Policy Manual Language on "Confined to the Home" Definition.
Definition: Mobility Assistive Equipment (MAE) DME200	**Annual Update** No criteria/definition changes or changes to relevant NCD. **CMS:** • National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3)
Dental Services: Administrative Guideline (All Lines of Business Except Medicare) **MED204**	**Annual Update** No change to criteria. The policy relies on Oregon House Bill 4128, which was updated to the 2019 version in references. No change to coverage.
Dental Services: Administrative Guideline (Medicare Only) MED428	**Annual Update** Update to new Medicare policy format, adding more detail to references and indications. No change to coverage. Continue to apply all previous Centers for Medicare & Medicaid Services (CMS) guidance. **CMS:** • Medicare General Information, Eligibility, and Entitlement, Publication 100-01, Chapter 5, Section 70.2 (*Scroll to Section 70.2 in table of contents, click on* 70.2 - Dentists) • Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Section 150 (*Scroll to Section 150 in table of contents, click on* 150 – Dental Services) • Medicare Benefit Policy Manual, Publication 100-02, Chapter 16: - General Exclusions From Coverage, Section 140 (*Scroll to Section 140 in table of contents, click on* 140 – Dental Services Exclusion) • Local Coverage Article (LCA): Routine Dental Services (A52977) • Noridian, Jurisdiction F – Medicare Part B, Dental Services

	• Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Section 150.1 (*Scroll to Section 150.1 in table of contents, click on* 150.1 - Treatment of Temporomandibular Joint (TMJ) Syndrome) • Medicare Benefit Policy Manual, Publication 100-02, Chapter 1: Inpatient Hospital Services Covered Under Part A, Section 70 (*Scroll to Section 70 in table of contents, click on* 70 – Inpatient Services in Connection with Dental Services) • Medicare National Coverage Determinations (NCD) Manual, Publication 100-03, Chapter 1, Part 4: Coverage Determinations, Section 260.6 (*Scroll to section 260.6 in table of contents, click on* 260.6 - Dental Examination Prior to Kidney Transplantation)
Eye: Corneal Collagen Cross-Linking (All Lines of Business Except Medicare) MED431	**Annual Update** No change to criteria **Codes/PA:** No change to coding/PA
Eye: Blepharoplasty, Blepharoptosis Repair, and Brow Lift (All Lines of Business Except Medicare) **SUR216**	**Annual Update** No change to criteria. Blepharoplasty, blepharoptosis repair, and brow lift – alone or in combination – may be considered medically necessary and covered when criteria are met. **Codes/PA:** No coding changes; 11 codes continue to require PA.
Eye: Retinopathy Telescreening **MED217**	**Annual Update** No change in coverage criteria. Recommendations continue to consider eye retinopathy screening medically necessary for individuals with diabetes mellitus without a diagnosis of diabetic retinopathy when imaging techniques are performed with an FDA approved device and final images are graded using a manual process. **Codes/PA:** No coding or PA changes **CMS:** As of March 2020, no Centers for Medicare & Medicaid (CMS) coverage guidance was identified which addresses retinopathy telescreening for the treatment of any indication.
Negative Pressure Wound Therapy (All Lines of Business Except Medicare) *Previously: Negative Pressure Would Therapy*	**Annual Update** Splitting out Medicare per new policy formatting. New policy title reflects this. No change to criteria. **Codes/PA:** No change to codes or PA **CMS:** This policy continues to reference Centers for Medicare & Medicaid documents as the basis of the policy criteria. Since the last update no changes were made to coverage in Local Coverage Determination (LCD) L33821 Negative Pressure Wound Therapy Pumps or Local Coverage Article (LCA): A52511 Negative Pressure Wound Therapy Pumps - Policy Article.

DME377	
Negative Pressure Wound Therapy (Medicare Only) **DME417**	**NEW** New Medicare format. Separated from DME377. No change to criteria. Continue to apply Local Coverage Determination (LCD) L33821 Negative Pressure Wound Therapy Pumps and Local Coverage Article (LCA): A52511 Negative Pressure Wound Therapy Pumps - Policy Article. **Codes/PA:** No change to coding or PA **CMS:** • Continue to apply: ○ LCD L33821 Negative Pressure Wound Therapy Pumps ○ LCA A52511 Negative Pressure Wound Therapy Pumps - Policy Article • Added reference to LCA A55426 Standard Documentation Requirements for All Claims Submitted to DME MACs
Non-Contact Wound Therapy (All Lines of Business Except Medicare) **MED379**	**Annual Update** No change in coverage criteria. Non-contact wound therapy, including low frequency ultrasound wound therapy and normothermic wound therapy, is considered investigational and is not covered. **Codes/PA:** No changes to coding or PA.
Non-Contact Wound Therapy (Medicare Only) **MED433**	**Annual Update** Criteria moved into new Medicare format. No changes to relevant Medicare coverage documents. **Codes/PA:** No changes to coding or PA **CMS:** • National Coverage Determination (NCD) for Noncontact Normothermic Wound Therapy (270.2)[i] • Local Coverage Determination (LCD) for Low Frequency, Non-contact, Non-thermal Ultrasound (MIST Therapy) (L37228) • Local Coverage Article (LCA) for Billing and Coding Wound Care (A55909)
Orthognathic Surgery **SUR296**	**Annual Update** No change to criteria. Continue to base policy on Oregon House Bill 4128. **Codes/PA:** No change to coding or PA
Proton Beam Radiation Therapy **MED324**	**Annual Update** No changes to criteria. Proton beam radiation therapy (PBRT) remains medically necessary and covered for the treatment of intracranial arteriovenous malformations, central nervous system tumors, intraocular melanomas, primary head and neck cancers and chordomas or chondrosarcomas located at the skull base or spine. Reirradiation with PBRT also remains medically necessary. Prostate cancer and other oncologic indications remain not medically necessary. **Codes/PA:** No coding changes; 5 codes continue to require PA. **CMS:** As of February 2020, no Centers for Medicare & Medicaid (CMS) coverage guidance was identified which addresses proton beam therapy for the treatment of any indication.
Standing Systems	**Annual Update**

(All Lines of Business Except Medicare) **DME345**	No change to coverage criteria. Medicare criteria now broken out into separate policy. Non-powered standing systems are considered medically necessary and covered when criteria are met. Standing wheelchairs, combination sit-to-stand frame/table systems, and standing devices used primarily as exercise equipment are considered not medically necessary. **Codes/PA:** No coding changes. 4 codes continue to require PA.
Standing Systems (Medicare Only) **DME418**	**New Policy** Medicare criteria now broken out into separate policy. No change to coverage criteria. Standing systems (e.g. tables, frames) and standing systems when used with wheelchairs remain not medically necessary and not covered. Combination sit-to-stand-frame table systems (E0637) are not addressed and will deny in accordance with our coverage hierarchy. **Codes/PA:** No coding changes **CMS:** • NCD for Durable Medical Equipment Reference List (280.1) • Local Coverage Determination (LCD): Wheelchair Options/Accessories (L33792) • Local Coverage Article (LCA): Wheelchair Options/Accessories - Policy Article (A52504)
Surgical Treatments for Lymphedema **SUR433**	**Annual Update** No change to criteria. Surgical treatments (i.e. excisional and physiologic procedures) remain investigational and not covered for the treatment of lymphedema. **Codes/PA:** No coding changes; 12 codes continue to PA **CMS:** There remains one LCD, "Plastic Surgery (L37020)", which has non-coverage guidance for suction-assisted lipectomy, which may be applied to lymphedema.
Tumor Treatment Field Therapy for Glioblastoma (All Lines of Business Except Medicare) **DME293**	**Annual Update** No change to coverage criteria. Tumor treatment fields (TTF) remain medically necessary and covered for the treatment of newly diagnosed glioblastoma and investigational for the treatment of recurrent glioblastoma. Contraindication statements added where relevant in criteria. Current note addressing prior authorization moved from coding table to "billing guidelines." **Codes/PA:** No coding changes; 2 codes continue to require PA
Tumor Treatment Field Therapy for Glioblastoma (Medicare Only) **DME413**	**Annual Update** No change to guidance documents. Tumor treatment field (TTF) therapy for the treatment of newly diagnosed glioblastoma remains medically necessary and covered when criteria are met. TTF for the treatment of recurrent glioblastoma remains not medically necessary. **Codes/PA:** No coding changes; 2 codes continue to PA **Medicare Guidance:** • Centers for Medicare & Medicaid Services Local Coverage Determination (LCD): Tumor Treatment Field Therapy (TTFT) (L34823) • Centers for Medicare & Medicaid Services Local Coverage Determination (LCD): Tumor Treatment Field Therapy (TTFT) (A52711)

PROVIDENCE Health Plan

VENDOR UPDATES

Updates to AIM Advanced Imaging Clinical Appropriateness Guideline

Effective for dates of service on and after **August 16, 2020**, the following updates will apply to the AIM Advanced Imaging of the Chest and AIM Oncologic Imaging Clinical Appropriateness Guidelines.

Advanced Imaging of the Chest updates by section:
Tumor or Neoplasm

- Allowed follow up of nodules less than 6 mm in size seen on incomplete thoracic CT, in alignment with follow up recommendations for nodules of the same size seen on complete thoracic CT
- Added new criteria for which follow up is indicated for mediastinal and hilar lymphadenopathy
- Separated mediastinal/hilar mass from lymphadenopathy, which now has its own entry

Parenchymal Lung Disease – not otherwise specified

- Removed as it is covered elsewhere in the document (parenchymal disease in Occupational lung diseases and pleural disease in Other thoracic mass lesions)

Interstitial lung disease (ILD), non-occupational including idiopathic pulmonary fibrosis (IPF)

- Defined criteria warranting advanced imaging for both diagnosis and management

Occupational lung disease (Adult only)

- Moved parenchymal component of asbestosis into this indication
- Added Berylliosis

Chest Wall and Diaphragmatic Conditions

- Removed screening indication for implant rupture due to lack of evidence indicating that outcomes are improved
- Limited evaluation of clinically suspected rupture to patients with silicone implants

Oncologic Imaging updates by section:
MRI breast

- New indication for BIA-ALCL
- New indication for pathologic nipple discharge

- Further define the population of patients most likely to benefit from preoperative MRI

Breast cancer screening

- Added new high risk genetic mutations appropriate for annual breast MRI screening

Lung cancer screening

- Added asbestos-related lung disease as a risk factor

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

PHARMACY & THERAPEUTICS COMMITTEE

None